DHS COVID-19 QUARANTINE AND ISOLATION (QI) MEDICAL SHELTERS POLICY AND PROCEDURE

Subject: **Harm Reduction – Alcohol (ETOH)**	Original Issue Date: N/A	Policy 18
		Effective Date: 4/20/21
Departments Consulted: Vagabond QI Clinical; QI Medical Shelter Director	Reviewed & Approved by: Housing for Health Medical Director; QI Medical Shelter Medical Director	

Harm Reduction

PURPOSE: The Los Angeles County Department of Health Services (DHS) Quarantine and Isolation (QI) Medical Shelters recognizes the impact of COVID-19 on individuals' overall health. Specifically, with respect to harm reduction, we aim to integrate the fundamentals of harm reduction while caring for those at risk of early exit or emergency room visits due to alcohol withdrawal or complications from other substance use or at-risk behaviors when they are admitted to Quarantine/Isolation due to COVID-19 at County designated facilities.

POLICY: All staff must understand and apply the concepts of Harm Reduction as specified in the Housing for Health Harm Reduction Position Statement (Appendix A) while caring for clients in QI Medical Shelters with the understanding that any person who reduces or discontinues ETOH consumption after chronic use is at risk of withdrawal.

SCOPE:

I. Applies to all County employees and contracted management, clinical and non-clinical staff involved with management of supplies, client assessments, or delivery of materials to individuals in quarantine status
II. Applies to individuals or clients who are in quarantine who plan on continuing the consumption of alcohol throughout any part of their duration in quarantine or self-isolation

PROCEDURE:

I. SCREENING

Any person who reduces or discontinues alcohol consumption after chronic use is at risk for alcohol withdrawal symptoms.

a. Medical intake will include an alcohol consumption assessment to identify persons at moderate-high risk of alcohol withdrawal vs low risk. Intake will also assess if they are currently in a substance use disorder treatment program (e.g., outpatient program, sober living environment, etc.) as well as assess their willingness to undergo medically assisted detox/sobering protocol while in the QI Medical Shelter.
    i. If patient is not in a program but is open to cessation, resources and on-site support will be made available before offering MAT or other harm reduction supplies. Protocols for withdrawal and overdose will be followed when appropriate.
b. Questions to ask client upon intake:
    i. Do you currently drink alcohol?

ii. How much and how often?
iii. Have you ever had seizures or "DTs" upon stopping?
iv. Have you ever had withdrawal symptoms? What kind?
v. Are you currently in a residential or outpatient treatment program for substance use? Name and contact of program?
vi. Are you willing to consider a detox/sobering protocol while in the QI Medical Shelter, including medications to prevent or minimize withdrawal symptoms if necessary?

c. Moderate-High risk persons are current alcohol consumers PLUS one of the following:
   i. Consumption of four or more standard drinks on most days
   ii. History of withdrawal seizures from benzodiazepines or alcohol
   iii. History of delirium tremens
   iv. Subjective report of experience of alcohol withdrawal symptoms
d. Low risk persons:
   i. Absence of any withdrawal history
   ii. Consumes less than 4 standard drinks daily
e. If client is moderate-high risk and agrees to detox/sobering protocol, gabapentin or chlordiazepoxide will be prescribed appropriately (see protocol, Appendix E).
f. Otherwise, Provider will order appropriate ETOH allotment and indicate their current SUD treatment program status if applicable. ETOH orders will be carried out as follows:
   i. Nursing to notify Community Partner
   ii. Community Partner logs patient name and alcohol limitations in their tracker
   iii. For guests at moderate to high risk of withdrawal, Provider shall estimate the client's baseline use, in standard drinks, in chart
      1. Standard drink definitions
         a. 1 standard drink = 12-ouce beer = 9-ouce malt liquor = 5-ouce wine = 1.5-ouce (a "shot") distilled spirit (e.g., vodka, rum, tequila, whiskey)
      2. Distilled spirits:
         a. ½ pint of distilled spirits = 4.5 standard drinks
         b. 1 pint of distilled spirits = 8.5 standard drinks
         c. A "fifth" of distilled spirits = 17 standard drinks
      3. Wine
         a. 1 table wine bottle = 5 standard drinks
         b. 1 3 Liter box wine = 20 standard drinks

II. SERVING ALCOHOL

a. General serving provisions:
   i. Alcoholic products will be provided to guests 21 and over unless determined otherwise by Provider, DMH or MAT Team consultation.
   ii. Alcoholic products should be consumed at the facility
   iii. For clients using stock alcoholic products, Community Partner's staff shall deliver the product(s) per Provider orders directly to the end user/guest.

iv. For clients using their own alcoholic products, Community Partner's staff shall store the product and deliver directly to the Client per Provider orders unless client has obtained approval to manage and self-administer own supply. Staff will distribute or make available alcoholic products during scheduled breaks.

b. Considerations for guests enrolled in or referred by a substance use disorder program
   i. To the extent possible, provide a supportive environment to help maintain a guest's recovery or sobriety during quarantine
   ii. Provide supportive measures and offer to link guests to their counselor or program for additional support
   iii. Provide alcohol per this protocol when other supportive measures are not feasible or available
   iv. Do not withhold alcohol for the sole reason a client is actively engaged in a SUD program
c. Serving quantity and frequency
   i. Use the following table to identify the amounts and frequency of alcohol that may be distributed to a guest based on their self-reported alcohol use upon intake

Self-reported daily consumption	Max Amount & Frequency	Daily limit*
1-3 standard drinks	1-2 standard drinks every 1 hour	3 drinks/day
4-6 standard drinks	2 standard drinks every 2-4 hours	6 drinks/day
7-10 standard drinks	3 standard drinks every 2-4 hours	10 drinks/day
11-15 standard drinks	3 standard drinks every 2-4 hours	15 drinks/day
16-20 standard drinks	4 standard drinks every 2-4 hours	20 drinks/day
>20 standard drinks	Consult provider	

*May periodically provide 1 or 2 additional standard drinks (exceeding max) if delivering additional drinks avoids risk of elopement or early exit and enhances comfort unless the person is intoxicated and presenting with behavioral challenge.

III. MONITORING

a. Moderate-high risk guests may require more frequent wellness checks
b. Guests actively engaged in a substance use disorder program may require more frequent wellness checks
c. Managing difficult situations:
   i. Consult RN and/or Provider if guest appears too intoxicated or presenting with other behavioral concern at any time
   ii. RNs will use the alcohol intoxication scale to objectively support further action (Appendix C) such as:
      1. Performing additional safety assessment(s)
      2. Withhold additional standard drinks for 1 or more hours
      3. Increase frequency of wellness checks

4. With consultation, the team may decide to reduce total daily limits of alcohol

d. Guest complains of withdrawal discomfort or exhibits physical symptoms of alcohol withdrawal:
   i. Provide additional drinks if they have not exceeded their limits
   ii. If the client has exceeded their limits then contact RN to perform a withdrawal assessment using SAWS-Alcohol Withdrawal (Appendix D) and provide additional standard drinks where necessary
   iii. RN shall consult a Provider for any guest with withdrawal symptoms that may require additional medical or pharmacological support

IV. ALCOHOL SUPPLY MANAGEMENT

a. All alcohol products intended for consumption shall be stored behind a locked door
b. Stock is managed by Community Partner
c. Stock will include common liquors available in 1.5 oz single dose packaging, 5 oz wine servings and 12 oz beer servings, each serving considered a *standard drink*
d. County will provide authorized Alcohol products in limited amounts as described above according to individual needs. Clients wishing to consume their own Alcohol may do so in lieu of stock with permission of the Provider or DMH Clinician, but the supply will be maintained by the Community Partner. Any unused supply belonging to the Client will be returned upon discharge.

V. DOCUMENTATION

a. Provider shall prescribe ETOH or other appropriate harm reduction measure
b. Nursing staff shall transcribe orders in MAR
c. Community Partner staff shall maintain an alcohol delivery log for each guest at the facility
   i. Community Partner staff shall check the alcohol delivery log prior to each delivery to avoid excessive alcohol distribution
   ii. Community Partner staff shall document the date, time, and quantity of standard drinks distributed on the log in real-time
d. All logs shall be securely stored but accessible to all staff involved in assessing, monitoring, or delivery of alcohol and persons monitoring or evaluating the overall service
e. Community Partner staff shall provide copies of alcohol delivery log to nursing staff at the end of each shift

VI. PRIVACY

a. Information about an individual guest request(s) for ETOH or ETOH consumption, or behaviors thereof, shall be treated with the same level of integrity as patient health information

VII. QUARANTINE EXIT

a. All precautions shall be taken to avoid dangerous activities for persons consuming alcohol on day of exit (e.g. driving, riding a bicycle)
b. Staff cannot provide additional alcohol products to persons "to go" upon exiting quarantine for any reason

REFERENCE:

- National Institute of Health. National Institute on Alcohol Abuse and Alcoholism (NIAAA): Alcohol's Effects on Health. 2020. Retrieved at: https://www.niaaa.nih.gov/alcohols-effects-health
- Alcohol Management for People Who Plan to Consume Alcohol During Quarantine or Isolation for COVID-19- a Pilot Service, Seth Gomez, PharmD, BCPP and Aaron Chapman, MD, Alameda County Department of Health, 4/7/2020

Appendix A
Housing for Health Policy Statement Regarding Harm Reduction in Quarantine and Isolation (QI) Medical Shelters During the COVID-19 Pandemic
Los Angeles County Department of Health Services (DHS)

The purpose of this statement is to ensure that all staff are familiar with Harm Reduction principles and practices and understand how to apply them in the care of clients at a QI Medical Shelter. It is intended to accompany the Policy and Procedures specific to Harm Reduction.

Definition:
Harm Reduction strategies aim to reduce the harms associated with certain behaviors such as smoking, substance use, sex, treatment non-adherence, domestic violence, or other behaviors related to mental health or characterological disorders.

The practice of Harm Reduction has evolved over time: It was originally defined in the 1980s, as an alternative to abstinence-only focused interventions for adults with Substance Use Disorder (SUD). It was observed that many people who used substances were not ready to stop. They could, however, be counseled and supported in using in less harmful ways. For example, a heroin injection drug user might be given clean needles in exchange for dirty ones to reduce his risk of acquiring or spreading HIV or Hepatitis C. He might also be introduced to less risky opioids like Methadone or Suboxone as alternatives to heroin thereby reducing risk of overdose and/or death.

Beyond substance use, Harm Reduction principles are now widely applied in the delivery of trauma-informed, patient-centered care of individuals who engage in a variety of behaviors that may pose risk to themselves or others. For example, a commercial sex worker may not be able to insist on condom use from her clients. She might, however, be prescribed Pre-exposure Prophylaxis (PREP) medication to prevent HIV infection. She might also be taught how to minimize the risk of violence by only working in safe physical environments or her choice of voicing a “safe word” to indicate she is feeling threatened or unsafe.
The basic tenets of Harm Reduction revolve around the following:

- All people engage in some level of risky behavior. Most people have difficulty stopping a risky behavior all together.
- All people can be supported to make decisions to minimize harm to themselves or others if they persist in risky behaviors.
- It is important to “meet people where they are at” and work with them over time to move them along the Harm Reduction spectrum.
- For example, a person with alcohol use disorder and cirrhosis may not want to stop drinking but they might be willing to
- have one drink less a day
- intersperse a regular beer with a non-alcoholic beer
- take Lactulose every day
- not drive if they have a bus pass OR
- start Naltrexone, a medication that causes people to drink less
- Any positive step in reducing harm is considered a success.
- Evidence shows that over time, with successive adoption of Harm Reduction practices, people can achieve improved safety and health. Abstinence from the harmful behavior, although desirable, is not the goal.

- It is never okay to stand in judgement of someone you are trying to help; check your prejudices at the door and remember that you are there to help the person be the healthiest person they choose to be at that time.
- Just because you are supporting them where they are at, it does not mean you "condone" their behavior. Instead, it means you accept that it exists and work with that person over time to change the behavior and reduce the harm it may be causing to them or others.

Application of Harm Reduction Principles/Practices at the QI Medical Shelters:
Many of the clients served in the DHS QI Medical Shelters have had traumatic lives and/or have behavioral health conditions that complicate their lives and decision-making. A trauma-informed, client-centered approach to their care is critical, as is application of Harm Reduction principles and practices while determining goals of care, delivering care, and managing client crises.
It is also important to consider the QI Medical Shelter stay as a point in time in the life of our clients. Clients referred to QI Medical Shelter from encampments may be in a safe and healthful environment for two weeks but, after discharge from QI Medical Shelter, may return to their lives in the streets. Any opportunity that QI Medical Shelter staff has to impart hope and solidarity, do motivational interviewing, teach Harm Reduction skills/concepts, and move people along the Harm Reduction spectrum has potential long-lasting implications and should not be underestimated. How we respect and treat people while they are with us may impact how they receive help and accompaniment in the future. Within the DHS QI Medical Shelter, the practice of Harm Reduction is most relevant to the care of clients with active substance use disorder, severe persistent mental illness (SPMI), and treatment adherence.

SUD
Clients who are actively using substances are welcome at DHS QI Medical Shelters. On admission, clients' belongings are searched for drugs and drug paraphernalia. As permissible by law, those substances are removed and kept in a secured location to be returned to the client on discharge. During the intake process, the admitting provider should assess the extent of the substance use as well as the risk for withdrawal and other adverse events should they not have access to their substance(s) of choice. Clients should be offered substance use counseling, Harm Reduction counseling, Harm Reduction skills-building, medications/supportive care to manage withdrawal symptoms, and medications for addiction treatment (MAT). Clients at risk for drug overdose should be given a box of Narcan nasal spray and instructed on its appropriate use. Although substance use is not condoned at the QI Medical Shelter, if clients are found to be using, they will not be discharged from the site. Rather, more intensive counseling and monitoring will be provided, and clients will be supported to maximize the practice of Harm Reduction while on site. If clients' ongoing substance use poses significant risk to other QI Medical Shelter staff or other program participants and that risk cannot be mitigated, they will be discharged from the QI Medical Shelter and transferred to other locations, including drug treatment centers that accept clients in COVID quarantine/isolation.

Please refer to separate Policy/Procedure documents regarding care of clients with Alcohol Use Disorder (AUD), Opiate Use Disorder (OUD), Stimulant Use Disorder, as well as Cannabis and Nicotine use.

Serious and Persistent Mental Illness (SPMI)

Clients with SPMI are welcome at DHS QI Medical Shelter. On admission, clients' belongings are searched for drugs and drug paraphernalia as well as any items that might be used as a weapon. As permissible by law, those items are removed and kept in a secured location to be returned to the client on discharge. During the intake process, the admitting provider should assess the extent of the mental health disorder and assess the risk for harm to self or others. Clients should be offered mental health counseling, Harm Reduction counseling, Harm Reduction skills-building, medications/supportive care to manage mental health symptoms, and medications for treatment of SPMI. Clients with active SPMI symptoms should be closely monitored and preventive measures put into place to minimize escalation. Trauma-informed de-escalation practices should be employed in the event of a mental health crisis (see Policy/Procedure for Crisis Management.) If clients' mental health symptoms pose significant risk to other QI Medical Shelter staff or clients and that risk cannot be mitigated, they will be discharged from the QI Medical Shelter and transferred to another locations, such as a psychiatric emergency room.

TREATMENT ADHERENCE

Clients at a QI Medical Shelter may decline treatment of certain medical or behavioral health conditions. For example, a client with very high blood pressure may decline to take a prescribed antihypertensive. If the client is clinically stable and not exhibiting signs or symptoms of hypertensive urgency, the client should be counseled on the risks/benefits of the antihypertensive medication and the receipt of counseling and client's response should be documented in the chart. Only if the client is exhibiting signs or symptoms of hypertensive urgency should 911 be called. Even after the EMT's arrival, the client can still refuse to be taken to the hospital--in which case the client should sign an "Against Medical Advice" form provided by the EMTs. The completed AMA should then be entered into the QI Medical Shelter medical chart (See Policy and Procedure for AMA cessation of care.) Staff should attempt to understand the client's explanatory model for his illness and provide education and counseling to support the client to make the best decision for himself at the time. Clients should not be discharged from the facility for "nonadherence" unless this poses an immediate safety risk for other clients, staff or the community at large.

Appendix B – Consumption Log

Subject: **Harm Reduction – Alcohol (ETOH)**	Effective Date 4/20/21	Policy 18
	Approved By: Housing for Health Medical Director QI Medical Shelter Medical Director	

DHS – CENTRAL LOS ANGELES QUARANTINE/ISOLTION SITE
DAILY ALCOHOL CONSUMPTION LOG

SHIFT: MORNING (7:00AM-3:00PM) OR SWING (3:00PM-12:00AM)

DATE:	TIME:	ROOM #	SPECIFY BEER OR LIQUOR:	QUANTITY IN OUNCES:

Sherman Consumption Log

			ALCOHOL		
Date	Time	Patient Room	vodka/wiskey/beer?	STAFF	

Appendix C - Rapid Intoxication Assessment Tool

Score of equal to, or greater than, 3 then do not give provided additional alcohol.

CRITERIA	SCORE			
SPEECH	0 Normal	1 Slurred; Slow	2 Mumbling	3 Disjointed; Unintelligible
COORDINATION	0 Regular walking and movements	1 Tripping	2 Unsteady; Tottering; Staggering	3 Falling; Difficulty coming to or maintaining a standing position
MENTAL SIGNS	0 Focused, appropriate behavior, judgement and emotions			3 Confused, disoriented, mood swings, overly angry & fighting
LEVEL OF CONSCIOUSNESS	0 Alert; Attentive	1 Drowsy; Easily aroused	2 Nodding off; Losing train of thought	3 Unable to have a conversation; unable to perform any task
PHYSICAL SIGNS	0 Normal breathing; Pupils reactive			3 Slow breathing***;** Pupils pinpoint

Appendix D - SAWS- Alcohol Withdrawal

Health Services
LOS ANGELES COUNTY

SAWS – Short Alcohol Withdrawal Scale

Patient Name: _____ **DOB:** _____ **Room:** _____

Date: _____ **Time:** _____

Item:	None (0 Point)	Mild (1 Point)	Moderate (2 Points)	Severe (3 Points)
Anxious				
Feeling confused				
Restless				
Miserable				
Problems with Memory				
Tremors (shakes)				
Nausea				
Heart Pounding				
Sleep Disturbance				
Sweating				

Mild Withdrawal < 12 Points

Score: _____

Moderate to Severe Withdrawal > or = 12 Points

Tool to assess the severity of alcohol withdrawal. Patients indicate how they have felt in the previous 24 hours.

*Adapted with permission from Elholm B, Larsen K, Hornnes N, Zierau F, Becker U. A Psychometric Validationof the Short Alcohol Withdrawal Scale (SAWS). Alcohol Alcohol 2010;45(4):362

Appendix E – Department of Health Services
Housing for Health QI Site Alcohol Withdrawal Standing Orders

1. Alcohol / Benzodiazepine / Barbiturate Withdrawal Standing Orders:

[ ] Patient reports significant recent alcohol / benzodiazepine / barbiturate use with plans to abstain from using these substances
If uncertain about symptoms of alcohol / benzodiazepine / barbiturate withdrawal, see SAWS but this scale does not need to be administered or documented prior to ordering the below
[ ] Provider will check in with patient over the phone q24 hours for days 1 to 3

I. For mild to moderate alcohol / benzodiazepine / barbiturate withdrawal without prior history of seizures or other medically complicated withdrawal:

[ ] Gabapentin Taper:

Provide the patient #30 tabs of 600mg gabapentin with instructions to take as below:
STAT Gabapentin 1,200 mg PO plus:
Day 1: Pt takes two additional gabapentin 1,200 mg doses if they report ongoing withdrawal symptoms
Day 2: Gabapentin 600mg TID plus additional 600mg dose if pt has ongoing withdrawal
Day 3: Gabapentin 600mg TID plus additional 600mg dose if pt has ongoing withdrawal
Day 4: Gabapentin 600mg TID plus additional 600mg dose if pt has ongoing withdrawal
Day 5: Gabapentin 600mg TID plus additional 600mg dose if pt has ongoing withdrawal
Day 6: Gabapentin 600mg TID plus additional 600mg dose if pt has ongoing withdrawal
Day 7: Gabapentin 600mg TID plus additional 600mg dose if pt has ongoing withdrawal
Day 8: Gabapentin 300mg TID
Day 9: Gabapentin 300mg BID
Day 10: Gabapentin 300mg qHS

II. If patient refuses or does not tolerate gabapentin:

[ ] Carbamazepine Taper:

Provide the patient #30 doses of 200mg carbamazepine with instructions to take as below:
Day 1: Pt takes 200mg carbamazepine QID
Day 2: 200mg carbamazepine QID
Day 3: 200mg carbamazepine QID
Day 4: 200mg carbamazepine TID
Day 5: 200mg carbamazepine TID
Day 6: 200mg carbamazepine TID
Day 7: 200mg carbamazepine BID
Day 8: 200mg carbamazepine BID

Day 9: 200mg carbamazepine BID
Day 10: 200mg carbamazepine qHS
Day 11: 200mg carbamazepine qHS

III. For moderate to severe alcohol / benzodiazepine / barbiturate withdrawal OR with prior history of seizures or other medically complicated withdrawal:

a. **Hold both Librium Ativan if RR < 10 or if the pt is asleep or has signs of over-sedation.**

[ ] Librium (aka chlordiazepoxide) Fixed Taper: For patients without decompensated liver disease
Dispense two doses of Librium to the patient twice a day. They take the first dose immediately and keep the 2nd dose to self-administer 4-6 hours later
STAT: Librium 50 mg PO, then in 6 hours:
Day 1: Librium 50 mg PO QID
Day 2: Librium 25 mg PO QID
Day 3: Librium 25 mg PO QID

[ ] PRN Librium 50 mg PO x 1, if pt reports significant withdrawal after one hour of receiving their most recent Librium dose
[ ] Call on-call Provider (on-site Provider or call 213-288-9090) if symptoms unresolved with 1 PRN dose or if client develops worsening withdrawal despite treatment.

[ ] Ativan (aka lorazepam) Taper: For patients with decompensated liver disease
Dispense two doses of Ativan to the patient twice a day. They take the first dose immediately and keep the 2nd dose to self-administer 3-4 hours later
STAT: Ativan 2 mg PO, then in three hours:
Day 1: Ativan 2 mg QID
Day 2: Ativan 1 mg QID
Day 3: Ativan 1 mg QID

[ ] PRN Ativan 1 mg PO x 1, if pt reports significant withdrawal after one hour of receiving their most recent Ativan dose
[ ] Call on-call Provider (on-site Provider or call 213-288-9090) if symptoms unresolved with 1 PRN dose or if client develops worsening withdrawal despite treatment.

2. Medications for Alcohol Use Disorder:
[ ] Patient reports problem alcohol use

a. Do not give naltrexone if pt has active ascites or jaundice and do not give if the pt is taking any opioids (including methadone or buprenorphine)

Provide the patient #30 tabs of 50mg naltrexone with instructions to take as below:

Day 1 and onward: Naltrexone 50 mg PO daily